

FOR ASSOCIATE USE ONLY:

Check the appropriate box:
 Send the insured's check to the agent for delivery.
 Contact the associate only if additional information is needed to complete processing of this claim.

Writing No.: _____ Name: _____
 Address: _____

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

Attention: Claims Department

Worldwide Headquarters: 1932 Wynnton Road Columbus Georgia 31999-7260

For information or help filing your claim, please call toll-free 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at www.aflac.com.
 Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

ACCIDENT AND DISABILITY CLAIM FORM

If you are filing an accident claim:

1. Complete Section A below; be sure to fully explain how you were injured.
2. Send us a copy of the hospital bill; if you were treated in the emergency room or a doctor's office, send us a copy of these bills also.
3. Ask your doctor to complete and sign Section C on the reverse side of this form for all claims and return the form to us at the above address.

If you are filing for disability benefits:

1. Complete Section A below; be sure to fully explain how you became disabled.
2. Your employer should answer the questions in Section B below. ***If you are self-employed:***
 - a. Answer all questions on this side, and
 - b. Send us a copy of your current business license (if required to be licensed) and your most recent quarterly tax returns.
3. Ask your doctor to complete and sign Section C on the reverse side of this form for all claims and return the form to us at the above address.

SECTION A: PATIENT'S INFORMATION Please answer each question COMPLETELY.

LAST	FIRST	MIDDLE	SEX	BIRTH DATE ____/____/____	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER	SOCIAL SECURITY #
ADDRESS STREET & NUMBER			CITY	STATE AND ZIP CODE	PHONE NUMBER	
<input type="checkbox"/> FULL-TIME STUDENT	RELATIONSHIP TO POLICYHOLDER		<input type="checkbox"/> SELF	POLICYHOLDER		POLICY NUMBER(S)
<input type="checkbox"/> PART-TIME STUDENT	<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD					

1. Is claim due to an accident or a disability caused by an accident? Yes No Date of accident: ____/____/____.
 Describe how accident occurred: _____
 If auto accident, was patient: driver passenger unknown ****If driver, a copy of the police report is required.****
2. Is claim due to disability caused by a sickness? Yes No If yes, briefly describe sickness: _____
3. Is claim due to disability related to pregnancy complications of pregnancy? Please explain: _____
 Are you pregnant now? Yes No Date of delivery or expected date of delivery: ____/____/____.

SECTION B: EMPLOYER'S INFORMATION Please complete if filing for disability.

Name and address of patient's employer: _____
 Number of hours per week: _____ Monthly salary: _____ Date of hire: ____/____/____ Is disability due to an accident that occurred on the job? Yes No If yes, name of Workers' Compensation carrier: _____
 Dates unable to work due to accident or sickness: ____/____/____ to ____/____/____ Is he/she still employed? Yes No If no, when did employment terminate? ____/____/____ If yes, please indicate date employee is expected to return to work. ____/____/____
 Please list job duties employee is unable to perform and the percentage of time this requires daily:
 _____ Less than 60% 60% or more
 _____ Less than 60% 60% or more
 Was employer authorization to include disability insurance signed? Yes No
 Does employer pay a portion of the disability premium for the employee? Yes No If yes, what percent? _____%
 Indicate if employee is exempt from the following deductions: Social Security Medicare Does the employee pay disability premiums with pre-tax dollars? Yes No If yes, FICA deductions will be deducted from claim payments.

Please note: the employer is required to report disability benefits paid on pre-tax plans on its Form 941 and the employee's Form W-2.

SIGNATURE OF EMPLOYER	TITLE	DATE
PLEASE PRINT FULL NAME	PHONE NUMBER	

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

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ACCIDENT AND DISABILITY CLAIM FORM

SECTION C: DOCTOR'S INFORMATION Please answer each question COMPLETELY.

LAST	FIRST	MIDDLE	SEX	BIRTH DATE / /	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	SOCIAL SECURITY NO.
ADDRESS STREET & NUMBER			CITY		STATE AND ZIP CODE	
RELATIONSHIP TO POLICYHOLDER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> OTHER			POLICYHOLDER'S NAME			POLICY NUMBER(S)

DIAGNOSIS	LIST ANY CHRONIC SICKNESS OR DISEASE	ONSET DATE

- Is this claim for: An accident A disability due to an accident? Give date and place of accident: _____
Give details of the accident:: _____
If auto accident, was patient: driver passenger unknown
- Is this claim for Disability due to sickness? Disability due to pregnancy? Disability due to complications of pregnancy?
Date of delivery or expected delivery: ____/____/____. Type of delivery: Vaginal Caesarean
If filing for complications, please explain: _____
- Is this accident/sickness covered by Medicaid/state aid? Yes No
- Symptoms first occurred on: ____/____/____. Patient first consulted you for this condition on ____/____/____.
- Has patient ever had same or similar condition? No Yes If yes, state when and describe: _____
- Referring physician (name/address): _____
- If patient was hospitalized for this condition, list dates and name(s) of hospital(s): _____

DATES OF SERVICE	PLACE OF SERVICE (IP/OP)	PROCEDURE DESCRIPTION	# UNITS	CODE: CPT/HCPCS/RVS	DIAGNOSIS CODE ICD.9	CHARGE

If patient is disabled, please answer Questions 5 through 8:

TOTAL

\$

- If patient is disabled, give dates of disability: from ____/____/____ to ____/____/____.
- What specific job duties is patient unable to perform? _____
- Is patient Ambulatory? Bed-confined? House-confined? Hospital-confined? Other? _____
- If retired or employed less than 30 hours per week, which activities of daily living (ADLs) is patient unable to perform?
Check all that apply: Continence Transferring Dressing Toileting Eating Bathing (PA only)

Date: _____, _____ Signed: _____
(Attending Physician)

Name of attending physician (please print): _____
Tax ID or Social Security Number

(Street Address) (City or Town) (State and Zip Code) (Area Code Phone)

I hereby request and authorize any health care provider to furnish to AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC) or its representative any and all medical information concerning any sickness or injury I may have suffered, including HIV testing and the diagnosis and treatment of communicable diseases, ARC, AIDS, chemical dependency or psychiatric sickness.

Persons signing may receive a copy of this authorization. Any copy of this authorization shall have the same authority as the original.

SIGNATURE OF PATIENT; IF MINOR, PARENT MUST SIGN DATE
If signed on behalf of another, state the relationship: _____ (Only if patient is unable to sign)
(Expires six months from date stated above unless indicated otherwise or revoked earlier.)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.